



## Complaint Form - Instructions for Filing a Complaint

Anyone with knowledge or concerns about the care of a patient or resident in a licensed health facility may file a complaint with their State Survey Agency. The State Survey Agency is the agency that has regulatory responsibility for all the health facilities in the state.

You may use the form below to file a complaint if you are concerned about the health care, treatment, or services that you or another person received or did not receive in the health care facilities. Some reasons for filing a complaint would be abuse, neglect, poor care, not enough staff, unsafe or unsanitary conditions, dietary problems, or mistreatment.

You do not have to use this form when filing a complaint. You may file a complaint with your State Survey Agency by any means available to you, including mail, telephone, fax, on-line, or in person. **Contact information can be found at the end of this form.**

**Step 1:** Please include as much information as possible when submitting your complaint. The response and timing of any investigation by your State Survey Agency will be based upon the information you provide.

Report a concern as soon as possible since it will be easier for you to remember the facts and will assist the State Survey Agency in gathering important information.

**Step 2:** Following receipt of your complaint, a representative from the State Survey Agency may contact you about your concerns for more information if needed.

**Step 3:** If your concern involves a possible violation of a Federal or State regulation, the State Survey Agency may conduct an investigation. The investigation may include a review of records, interviews with staff, patients or residents, and the observation of patient or resident care.

**Step 4:** At the end of the complaint review, the State Survey Agency will notify you of the results if you provide your contact information in Section 1 on the complaint form.

### Section 1. Person Filling Out the Complaint Form

Check box below to remain anonymous \*

Report Anonymously

First Name

Last Name

Address:

City:

State:

Zip Code:

Primary Telephone:

Secondary Telephone:

E-mail

Best time(s) to contact you (please check all that apply):

Morning

Afternoon

Evening

\*You can remain anonymous, but if you choose to reveal your personal information we will not release it to the facility or anyone else.

Mandatory reporters cannot submit an anonymous complaint. However, personal information, including name, will be treated as confidential.

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## Section 2. Facility Information

Facility Name

Telephone Number

Address

City:

State:

Zip Code:

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## Section 3. Patient/Resident Information

Patient/Resident Name (First & Last):

Date of Birth (if known):

What is your relationship to the Patient/Resident?

Patient/ Resident (Self)

Family Member

Friend

Guardian/Power of Attorney

Present/Former Facility Employee

Anonymous

Ombudsman

Law Enforcement

Quality Improvement Organization

Other

Is the Patient/Resident still in the facility?

No

Yes

Do not know

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## Section 4. Complaint Information

Date of incidence:

Time of incidence

**Names of any other person(s) or witness(es) involved in this complaint:**

First & Last Name:

Contact information if known:

First & Last Name:

Contact information if known:

First & Last Name:

Contact information if known:

First & Last Name:

Contact information if known:

Please describe what happened. Be as detailed as possible (add additional pages or attachments if needed).

## Section 5. Reporting of the Complaint

Did you report this complaint to the facility staff?

No                      Yes\*\*

Date the Complaint was reported to the facility staff:

\*\* If yes, please complete Section 5 in its entirety.

Name & Title of staff who received the complaint:

What action was taken by the facility?

Did you report this complaint or incident to any other agency?

Long Term Care Ombudsman

Law Enforcement Agency

Adult Protective Services

Attorney General

Other

**Please submit this completed form to:**



Health Facilities Licensing & Certification  
Attn: Complaint Coordinator  
4601 Business Park Blvd., Bldg. K  
Anchorage, AK 99503

Phone: (907) 334-2483

Secure Fax: (907) 334-2682

Toll Free: (888) 387-9387

By Secure Email (**ONLY if you have an existing Direct Secure Messaging (DSM) account**): [DHCS.HFLC@hss.soa.directak.net](mailto:DHCS.HFLC@hss.soa.directak.net)

**NOTE: The fax number above is a secured line specifically for complaints and only authorized staff have access.**